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106TH CONGRESS
1ST SESSION

H. R. 1133

To provide for comprehensive reform for managed health care plans.

IN THE HOUSE OF REPRESENTATIVES

MARCH 16, 1999

Mr. NADLER (for himself and Mr. FROST) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for comprehensive reform for managed health care plans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Comprehensive Managed Health Care Reform Act of
6 1999”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 this Act is as follows:

- Sec. 1. Short title; table of contents.
Sec. 2. Definitions.

- Sec. 3. Enforcement of requirements.
- Sec. 4. Assuring adequate access to covered services and providers.
- Sec. 5. Assuring adequate scope of coverage.
- Sec. 6. Assuring unbiased medical determinations by health care professionals and providers.
- Sec. 7. Nondiscrimination against enrollees and in the selection of participating providers; equitable access to networks.
- Sec. 8. Disclosure of information.
- Sec. 9. Grievance procedures and deadline for responding to requests for coverage of services.
- Sec. 10. Due process for health care professionals and providers.
- Sec. 11. Requirements for quality improvement program and utilization review programs.
- Sec. 12. Minimum loss ratios; general consumer protections.

1 SEC. 2. DEFINITIONS.

2 (a) IN GENERAL.—For purposes of this Act:

3 (1) ENROLLEE.—The term “enrollee” means,
 4 with respect to a managed care plan offered by a
 5 managed care organization, an individual enrolled
 6 with the organization for coverage under such a
 7 plan.

8 (2) HEALTH CARE PROFESSIONAL.—The term
 9 “health care professional” means a physician or
 10 other health care practitioner who is licensed under
 11 State law with respect to the health care services the
 12 practitioner furnishes.

13 (3) HEALTH PLAN.—The term “health plan”
 14 means a group health plan or health insurance cov-
 15 erage offered by a health insurance issuer.

16 (4) MANAGED CARE ORGANIZATION.—The term
 17 “managed care organization” means any entity, in-
 18 cluding a group health plan, health maintenance or-
 19 ganization, or provider-sponsored organization, in re-

1 lation to its offering of a managed care plan, and in-
2 cludes any other entity that provides or manages the
3 coverage under such a plan under a contract or ar-
4 rangement with the entity.

5 (5) MANAGED CARE PLAN.—The term “man-
6 aged care plan” means a health plan offered by an
7 entity if the entity—

8 (A) provides or arranges for the provision
9 of health care items and services to enrollees in
10 the plan through participating health care pro-
11 fessionals and providers, or

12 (B) provides financial incentives (such as
13 variable copayments and deductibles) to induce
14 enrollees to obtain benefits through partici-
15 pating health care professionals and providers,
16 or both.

17 (6) PARTICIPATING.—The term “participating”
18 means, with respect to a health care professional or
19 provider in relation to a health plan offered by an
20 entity, a physician or provider that furnishes health
21 care items and services to enrollees of the entity
22 under an agreement with the entity.

23 (7) PRIMARY CARE PROVIDER.—The term “pri-
24 mary care provider” means a health care profes-

1 sional who acts as a gatekeeper for the overall care
2 of an enrollee.

3 (8) SECRETARY.—The term “Secretary” means
4 the Secretary of Health and Human Services .

5 (9) STATE.—The term “State” includes the
6 District of Columbia, Puerto Rico, the Virgin Is-
7 lands, Guam, American Samoa, and the Northern
8 Mariana Islands.

9 (b) INCORPORATION OF GENERAL DEFINITIONS
10 FROM HEALTH INSURANCE PORTABILITY AND ACCOUNT-
11 ABILITY ACT.—For purposes of this Act, the definitions
12 contained in section 2791 of the Public Health Service Act
13 (42 U.S.C. 300gg–91) shall apply under this Act.

14 **SEC. 3. ENFORCEMENT OF REQUIREMENTS.**

15 (a) APPLICATION TO GROUP HEALTH PLANS.—

16 (1) PUBLIC HEALTH SERVICE ACT.—For pur-
17 poses of applying title XXVII of the Public Health
18 Service Act, the requirements of the succeeding sec-
19 tions of this Act shall be treated as though they
20 were included in the subpart 2 of part A of such
21 title (42 U.S.C. 300gg–4 et seq.).

22 (2) EMPLOYEE RETIREMENT INCOME SECURITY
23 ACT OF 1974.—For purposes of applying part 7 of
24 subtitle B of title I of the Employee Retirement In-
25 come Security Act of 1974, the requirements of the

1 succeeding sections of this Act shall be treated as
2 though they were included in subpart B of such part
3 (29 U.S.C. 1185 et seq.).

4 (3) INTERNAL REVENUE CODE OF 1986.—For
5 purposes of applying chapter 100 of the Internal
6 Revenue Code of 1986, the requirements of the suc-
7 ceeding sections of this Act shall be treated as
8 though they were included in subchapter B of such
9 chapter.

10 (b) APPLICATION TO INDIVIDUAL HEALTH INSUR-
11 ANCE COVERAGE.—For purposes of applying title XXVII
12 of the Public Health Service Act, the requirements of the
13 succeeding sections of this Act also shall be treated as
14 though they were part of subpart 2 of part B of such title
15 (42 U.S.C. 300gg-51 et seq.).

16 (c) MEDICARE.—The Secretary may not enter into
17 a contract under section 1857 of the Social Security Act
18 (42 U.S.C. 1395w-27) with a Medicare+Choice organiza-
19 tion that is a managed care organization unless the con-
20 tract contains assurances satisfactory to the Secretary
21 that the organization will comply with the applicable re-
22 quirements of the succeeding sections of this Act.

23 (d) MEDICAID.—Notwithstanding any other provision
24 of law, no funds shall be paid to a State under section
25 1903(a)(1) of the Social Security Act (42 U.S.C.

1 1396b(a)(1)) with respect to medical assistance provided
2 through payment to a Medicaid managed care organiza-
3 tion (as defined in section 1903(m)(1)(A) of such Act, 42
4 U.S.C. 1396b(m)(1)(A)) unless the contract with such or-
5 ganization contains assurances satisfactory to the Sec-
6 retary that the organization will comply with the applica-
7 ble requirements of the succeeding sections of this Act.

8 (e) SECRETARIAL ENFORCEMENT AUTHORITY.—

9 (1) IN GENERAL.—In addition to any other au-
10 thority provided under law, the Secretary shall es-
11 tablish sanctions, consistent with this subsection, for
12 the enforcement of the requirements of the suc-
13 ceeding sections of this Act.

14 (2) PROGRESSIVE CIVIL MONETARY PEN-
15 ALTIES.—Such sanctions shall include the imposition
16 of civil monetary penalties for violations of such re-
17 quirements. The amount of such penalties shall in-
18 crease as the frequency or severity of the violations
19 by a managed care organization increases.

20 (3) OPPORTUNITY FOR CORRECTIVE ACTION
21 PLAN.—The Secretary shall provide an opportunity
22 for a managed care organization to implement a cor-
23 rective action plan before imposing sanctions for vio-
24 lations of such requirements.

1 (4) DISQUALIFICATION FROM MEDICARE AND
2 MEDICAID.—In cases of repeated or egregious viola-
3 tions of such requirements by such an organization
4 that has entered into a contract under title XVIII or
5 XIX of the Social Security Act—

6 (A) the Secretary initially shall prohibit
7 the organization from enrolling any additional
8 individuals under either such title, and

9 (B) if the Secretary finds that the viola-
10 tions continue, the Secretary shall terminate
11 the contracts with the organization under such
12 titles and require the termination of enrollment
13 of individuals enrolled with the organization
14 under either such title.

15 (5) PRINTING LIST OF VIOLATORS.—The Sec-
16 retary shall periodically publish a list of the organi-
17 zations which have been sanctioned under this sub-
18 section, the nature of such sanctions, and the viola-
19 tions for which such sanctions were imposed. The
20 Secretary may exclude from such list an organiza-
21 tion that, in lieu of imposition of a sanction, is im-
22 plementing (or has completed implementation of) a
23 corrective plan.

24 (f) ADDITIONAL LIABILITY FOR WITHHOLDING OF
25 MEDICALLY NECESSARY CARE.—If a managed care orga-

1 nization in connection with a managed care plan fails
2 (through the curtailment of a hospital stay, a limitation
3 on covered tests, a limitation on treatment, or otherwise)
4 to provide any such benefit in accordance with the terms
5 of the plan, insofar as such failure occurs pursuant to a
6 clinically or medically inappropriate decision or determina-
7 tion resulting from—

8 (1) the application of any cost containment
9 technique,

10 (2) any utilization review directed at cost con-
11 tainment, or

12 (3) any other medical care delivery policy deci-
13 sion which restricts the ability of providers of med-
14 ical care from utilizing their full discretion for treat-
15 ment of enrollees,

16 the organization, and any agent of the organization having
17 authority to make such decision or determination on be-
18 half of the organization, shall be jointly and severally lia-
19 ble to any enrollee aggrieved by such failure for actual
20 damages (including compensatory and consequential dam-
21 ages) proximately caused by such failure, and may, in the
22 court's discretion, be liable to such enrollee for punitive
23 damages. The remedies under this subsection are in addi-
24 tion to remedies otherwise provided under this section.

25 (g) NO PREEMPTION OF STRICTER STATE LAW.—

(1) IN GENERAL.—Subject to paragraph (2), this Act shall not be construed to supersede any provision of State law that provides protections in relation to health insurance coverage that are greater than the protections provided under this Act.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(h) NULLIFICATION OF CONTRARY CONTRACTUAL PROVISIONS.—Any contract provision or agreement that is in violation of any provision of this Act (or amendment made by this Act) shall be null and void.

SEC. 4. ASSURING ADEQUATE ACCESS TO COVERED SERVICES AND PROVIDERS.

(a) GENERAL ACCESS.—

(1) IN GENERAL.—Subject to paragraph (2), a managed care organization offering a managed care plan shall establish and maintain adequate arrangements, as defined under regulations of the Secretary, with a sufficient number, mix, and distribution of health care professionals and providers to assure

1 that covered items and services are available and ac-
2 cessible to each enrollee under the plan—

3 (A) in the service area of the organization;

4 (B) in a variety of sites of service;

5 (C) with reasonable promptness (including
6 reasonable hours of operation and after-hours
7 services);

8 (D) with reasonable proximity to the resi-
9 dences and workplaces of enrollees; and

10 (E) in a manner that—

11 (i) takes into account the diverse
12 needs of enrollees, and

13 (ii) reasonably assures continuity of
14 care.

15 (2) TREATMENT OF ORGANIZATIONS SERVING
16 CERTAIN AREAS.—For a managed care organization
17 that serves a rural or medically underserved area,
18 the organization shall be treated as meeting the re-
19 quirement of paragraph (1) if the organization has
20 arrangements with a sufficient number, mix, and
21 distribution of health care professionals and pro-
22 viders having a history of serving such areas. The
23 use of telemedicine and other innovative means to
24 provide covered items and services by a managed
25 care organization that serves a rural or medically

underserved area shall also be considered in determining whether the requirement of such paragraph is met.

(3) DEFINITIONS.—For purposes of paragraph (1):

(A) MEDICALLY UNDERSERVED AREA.—

The term “medically underserved area” means an area that is designated as a health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e) or as a medically underserved area for purposes of section 330 or 1302(7) of such Act (42 U.S.C. 254c, 300e–1(7)).

(B) RURAL AREA.—The term “rural area”

means an area that is not within a Standard Metropolitan Statistical Area or a New England County Metropolitan Area (as defined by the Office of Management and Budget).

(b) ACCESS TO SPECIALIZED SERVICES.—

(1) IN GENERAL.—A managed care organization shall demonstrate that enrollees have access to specialized treatment expertise when such treatment is medically or clinically indicated in the professional judgment of the treating health care professional, in consultation with the enrollee.

1 (2) MEDICAL SPECIALISTS.—A managed care
2 organization shall develop a system to permit enroll-
3 ees to use a medical specialist primary care provider
4 as a primary care provider when the enrollee's med-
5 ical conditions (including suffering from a chronic
6 disease or medical condition) warrant it.

7 (3) STANDING REFERRALS TO SPECIALISTS.—A
8 managed care organization shall provide for a stand-
9 ing referral to a medical specialist if the treating
10 primary care provider, in consultation with such spe-
11 cialists, determines such a referral is necessary to
12 provide adequate and continuous care for the pa-
13 tient.

14 (4) SPECIALIZED TREATMENT EXPERTISE DE-
15 FINED.—For purposes of this subsection, the term
16 “specialized treatment expertise” means expertise in
17 diagnosing or treating—

18 (A) unusual diseases or conditions, or

19 (B) diseases and conditions that are un-
20 usually difficult to diagnose or treat.

21 (5) MEDICAL SPECIALIST DEFINED.—For pur-
22 poses of paragraph (2), the term “medical spe-
23 cialist” means, with respect to a managed care orga-
24 nization, a health care professional who is certified
25 by a national accreditation board (or pursuant to

1 State licensing authority) as possessing specialized
2 treatment expertise.

3 (c) USE OF GYNECOLOGISTS AS PRIMARY CARE PRO-
4 VIDERS.—A managed care organization may not require
5 an enrollee to obtain a referral from a physician in order
6 to obtain covered items and services from a physician who
7 specializes in obstetrics and gynecology.

8 (d) EMERGENCY AND URGENT CARE.—

9 (1) IN GENERAL.—A managed care organiza-
10 tion shall—

11 (A) assure the availability and accessibility
12 of medically or clinically necessary emergency
13 services and urgent care services within the
14 service area of the organization 24 hours a day,
15 7 days a week;

16 (B) require no prior authorization for
17 items and services furnished in a hospital emer-
18 gency department to an enrollee (without re-
19 gard to whether the health care professional or
20 hospital has a contractual or other arrangement
21 with the organization) with symptoms that
22 would reasonably suggest to a prudent
23 layperson that there is an emergency medical
24 condition (including items and services de-
25 scribed in subparagraph (C)(iii));

1 (C) cover (and make reasonable payments
2 for)—

3 (i) emergency services,

4 (ii) services that are not emergency
5 services but are described in subparagraph
6 (B),

7 (iii) medical screening examinations
8 and other ancillary services necessary to
9 diagnose, treat, and stabilize an emergency
10 medical condition, and

11 (iv) urgent care services,
12 without regard to whether the health care pro-
13 fessional or provider furnishing such services
14 has a contractual (or other) arrangement with
15 the organization; and

16 (D) make prior authorization determina-
17 tions for—

18 (i) services that are furnished in a
19 hospital emergency department (other than
20 services described in clauses (i) and (iii) of
21 subparagraph (C)), and

22 (ii) urgent care services,
23 within the time periods specified in (or pursu-
24 ant to) sections 9(c)(3) and 10(f).

(2) DEFINITIONS.—For purposes of this subsection:

(A) EMERGENCY MEDICAL CONDITION.—

The term “emergency medical condition” means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention might result in—

(i) placing the patient’s health in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(B) EMERGENCY SERVICES.—The term “emergency services” means health care items and services that are necessary for the diagnosis, treatment, and stabilization of an emergency medical condition.

(C) URGENT CARE SERVICES.—The term “urgent care services” means health care items

1 and services that are necessary for the treat-
2 ment of a condition that—

3 (i) is not an emergency medical condi-
4 tion,

5 (ii) requires prompt medical or clinical
6 treatment, and

7 (iii) poses a danger to the patient if
8 not treated in a timely manner, as defined
9 by the Secretary in consultation with rel-
10 evant treating health care professionals or
11 providers.

12 (e) RIGHT TO REFERRAL TO NONPARTICIPATING
13 PROVIDERS.—A managed care organization shall permit
14 an enrollee to obtain a referral to a nonparticipating pro-
15 vider if the organization does not have a participating pro-
16 vider with appropriate training and experience to meet the
17 enrollee's needs and shall pay for care provided pursuant
18 to such a referral.

19 (f) ACCESS TO CENTERS OF EXCELLENCE FOR INDIV-
20 IDUALS REQUIRING SPECIALIZED CARE.—

21 (1) IN GENERAL.—Each managed care organi-
22 zation shall demonstrate that enrollees who have
23 chronic diseases or otherwise require specialized
24 services, as determined by the primary care provider
25 or treating specialist, have access through the orga-

1 nization to specialized treatment expertise at des-
2 ignated centers of excellence in order to provide ade-
3 quate and continuous care for such enrollees. Such
4 an organization shall demonstrate such access ac-
5 cording to standards developed by the Secretary, in-
6 cluding requirements relating to arrangements with
7 such centers and referral of enrollees to such cen-
8 ters.

9 (2) DESIGNATION PROCESS.—The Secretary
10 shall establish a process for the designation of facili-
11 ties as centers of excellence for purposes of this sub-
12 section. A facility may not be designated unless the
13 facility is determined—

14 (A) to provide specialty care,

15 (B) to deliver care for complex cases re-
16 quiring specialized treatment or for individuals
17 with chronic diseases, and

18 (C) to meet other requirements that may
19 be established by the Secretary relating to spe-
20 cialized education and training of health care
21 professionals, participation in peer-reviewed re-
22 search, or treatment of patients from outside
23 the geographic area of the facility.

24 (g) PATIENT ACCESS TO CLINICAL STUDIES.—

1 (1) PERMITTING PARTICIPATION IN APPROVED
2 CLINICAL STUDIES.—A managed care organization
3 may not deny (or limit or impose additional condi-
4 tions on) coverage of items and services furnished to
5 an enrollee if—

6 (A) the enrollee is participating in an ap-
7 proved clinical study,

8 (B) the items and services are furnished
9 according to the design of the study or to treat
10 conditions resulting from participation in the
11 study, and

12 (C) the items and services would otherwise
13 be covered by the organization except for the
14 fact that they are provided in connection with
15 participation in such a study.

16 Such an organization may not discriminate against
17 an enrollee on the basis of the enrollee's participa-
18 tion in such a study.

19 (2) CONSTRUCTION.—Nothing in paragraph (1)
20 shall be construed as requiring an organization to
21 provide for payment for items and services routinely
22 paid for as part of an approved clinical study.

23 (3) APPROVED CLINICAL STUDY DEFINED.—
24 For purposes of this subsection, the term “approved
25 clinical study” means—

1 (A) a research study approved by the Sec-
2 retary, the Director of the National Institutes
3 of Health, the Commissioner of the Food and
4 Drug Administration, the Secretary of Veterans
5 Affairs, the Secretary of Defense, or a qualified
6 nongovernmental research entity (as defined in
7 guidelines of the National Institute of Health),
8 or

9 (B) a peer-reviewed and approved research
10 program, as defined by the Secretary, con-
11 ducted for the primary purpose of determining
12 whether or not a treatment is safe, efficacious,
13 or having any other characteristic of a treat-
14 ment which must be demonstrated in order for
15 the treatment to be medically necessary or ap-
16 propriate.

17 (h) ACCESS TO EXPERIMENTAL TREATMENTS.—A
18 managed care organization shall provide access to experi-
19 mental treatments in the case of enrollees who have a life-
20 threatening disease or condition, when determined to be
21 medically necessary and appropriate by the treating health
22 care provider in consultation with the enrollee.

23 (i) REQUIREMENTS REGARDING USE OF PRESCRIP-
24 TION DRUG FORMULARIES.—

1 (1) IN GENERAL.—A managed care organiza-
2 tion shall provide coverage for a prescribed drug, ap-
3 proved for dispensing by the Food and Drug Admin-
4 istration, whether or not such drug is on a prescrip-
5 tion drug formulary used by the organization if the
6 use of such drug is judged to be medically necessary
7 and appropriate by the prescribing health care pro-
8 fessional.

9 (2) NOT PERMITTING CHANGES IN PRESCRIP-
10 TIONS.—No pharmacist or health care facility shall
11 change the prescription prescribed by a health care
12 provider, or change the drug dispensed to carry out
13 a prescription for an enrollee of a managed care
14 plan unless—

15 (A) the prescribing health care provider
16 has approved the change, and

17 (B) the enrollee has been informed and
18 given consent to the change.

19 (3) USE OF GENERICS PERMITTED.—Nothing
20 in this subsection shall be construed as preventing a
21 managed care organization from using medically ap-
22 proved generic drugs.

23 **SEC. 5. ASSURING ADEQUATE SCOPE OF COVERAGE.**

24 (a) COVERAGE OF PRESCRIPTION DRUGS, PREVEN-
25 TIVE SERVICES, AND INPATIENT AND OUTPATIENT SERV-

1 ICES.—A managed care organization, in offering coverage
2 under a managed care plan, shall include coverage of pre-
3 scription drugs, preventive services, and inpatient and out-
4 patient services, and shall—

5 (1) include coverage of annual screening mam-
6 mography for any female enrollee who is 40 years of
7 age or older and for any female enrollee who is less
8 than 40 years of age and who has a medical condi-
9 tion that makes such coverage medically necessary
10 and appropriate;

11 (2) not restrict benefits for any hospital length
12 of stay in connection with—

13 (A) a mastectomy for the treatment of
14 breast cancer to less than 48 hours, or

15 (B) a lymph node dissection for the treat-
16 ment of breast cancer to less than 24 hours;
17 and

18 (3) not exclude or restrict benefits—

19 (A) for prescription contraceptive drugs or
20 devices approved by the Food and Drug Admin-
21 istration, or generic equivalents approved as
22 substitutable by the Food and Drug Adminis-
23 tration, or

24 (B) for outpatient contraceptive services
25 (including consultations, examinations, proce-

1 dures, and medical services, provided on an out-
2 patient basis and related to the use of contra-
3 ceptive methods (including natural family plan-
4 ning) to prevent an unintended pregnancy).

5 (b) MENTAL HEALTH PARITY.—A managed care or-
6 ganization, in offering a managed care plan, may not dis-
7 tinguish in the amount, duration, or scope of coverage
8 under the plan among items and services based on whether
9 the items and services relate to mental health (or treat-
10 ment of mental illness or disease) or to physical health
11 (or treatment of physical illness or disease).

12 (c) COVERAGE OF SERVICES OF ESSENTIAL COMMU-
13 NITY PROVIDERS.—

14 (1) IN GENERAL.—The Secretary may require a
15 managed care organization to enter into agreements
16 with essential community providers serving the orga-
17 nization's service area (in relation to the coverage)
18 to join the organization's provider network if such
19 Secretary finds that such agreements are necessary
20 for the organization to make contracted for services
21 (A) available and accessible to each enrollee, within
22 the area served by the organization (in relation to
23 such coverage), with reasonable promptness and in
24 a manner which assures continuity, and (B) when

1 medically necessary, available and accessible 24
2 hours a day and 7 days a week.

3 (2) ESSENTIAL COMMUNITY PROVIDER DE-
4 FINED.—For purposes of paragraph (1), the term
5 “essential community provider” means a rural
6 health clinic (described in paragraph (2) of section
7 1861(aa) of the Social Security Act, 42 U.S.C.
8 1395x(aa)), a Federally qualified health center (de-
9 scribed in paragraph (4) of such section), and any
10 other provider meeting such standards as the Sec-
11 retary may require.

12 (d) COVERAGE OF EMERGENCY SERVICES.—A man-
13 aged care organization shall provide for coverage of emer-
14 gency services (as defined in section 4(d)(2)(B)), 24-hours
15 a day, 7-days-a-week, without the need for any prior ap-
16 proval for coverage of such services.

17 (e) REQUIREMENT FOR POINT OF SERVICE OP-
18 TION.—A managed care organization that offers a man-
19 aged care plan shall offer each enrollee an enrollment op-
20 tion under which the enrollee may receive benefits for serv-
21 ices provided by nonparticipating health care professionals
22 and providers. The organization may require that the en-
23 rollee pay a reasonable premium to reflect the cost of such
24 option.

1 (f) REQUIREMENT FOR CONTINUITY OF CARE.—A
2 managed care organization shall provide for continuity of
3 care following enrollment, including appropriate continuity
4 of care following termination of participation of a provider
5 that is providing a course of treatment to an enrollee at
6 the time of the termination.

7 (g) COVERAGE OF CONSULTATION FOR SECOND
8 OPINIONS.—A managed care organization shall provide
9 enrollees with access to a consultation for a second opinion
10 regarding treatment options.

11 **SEC. 6. ASSURING UNBIASED MEDICAL DETERMINATIONS**
12 **BY HEALTH CARE PROFESSIONALS AND PRO-**
13 **VIDERS.**

14 (a) REQUIRING MEDICAL DETERMINATIONS BY
15 TREATING PROFESSIONAL.—A managed care organiza-
16 tion may not deny payment for services covered under a
17 managed care plan based upon the fact that the services
18 are not medically necessary or appropriate with respect
19 to an enrollee unless the determination is made solely by
20 the health care professional treating the enrollee.

21 (b) PROHIBITION OF CERTAIN INCENTIVE ARRANGE-
22 MENTS.—

23 (1) IN GENERAL.—No managed care organiza-
24 tion shall offer monetary rewards, penalties, or in-
25 ducements (including varying the amount of com-

1 pensation) to a health care professional or provider,
2 or condition the initial or continued participation of
3 such a professional or provider in a managed care
4 plan offered by the organization, on the basis of the
5 professional's or provider's decision (or decisions) to
6 reduce or limit the availability of appropriate med-
7 ical tests, services, or treatment, on the basis of any
8 utilization review decisions relating to the profes-
9 sional or provider, or the number of referrals, tests,
10 or other procedures ordered or performed by the
11 professional or provider.

12 (2) PENALTY.—Any managed care organiza-
13 tion, or executive of such an organization, that
14 knowingly offers a reward, penalty, or inducement in
15 violation of paragraph (1) shall be fined in accord-
16 ance with title 18, United States Code, imprisoned
17 for not more than 2 years, or both.

18 (c) PROHIBITION OF INTERFERENCE WITH CERTAIN
19 MEDICAL COMMUNICATIONS.—

20 (1) IN GENERAL.—The provisions of any con-
21 tract or agreement, or the operation of any contract
22 or agreement, between a managed care organization
23 and a health care professional shall not prohibit or
24 restrict the health care professional from engaging

1 in medical communications with a patient of the pro-
2 fessional.

3 (2) MEDICAL COMMUNICATION DEFINED.—For
4 purposes of this subsection, the term “medical com-
5 munication” means a communication made by a
6 health care professional with a patient of the health
7 care professional (or the guardian or legal represent-
8 ative of the patient) with respect to—

9 (A) the patient’s health status, medical
10 care, or treatment options;

11 (B) any utilization review requirements
12 that may affect treatment options for the pa-
13 tient; or

14 (C) any financial incentives that may af-
15 fect the treatment of the patient.

16 (d) WHISTLEBLOWER PROTECTION.—

17 (1) IN GENERAL.—No managed care organiza-
18 tion may discharge or otherwise discriminate against
19 any employee with respect to compensation, terms,
20 conditions, or privileges of employment because the
21 employee (or any person acting pursuant to the re-
22 quest of the employee) provided information to a
23 Federal or State official with any enforcement re-
24 sponsibility or authority concerning the provisions of
25 this Act regarding a possible violation of any provi-

1 sion of this Act, or any regulation under any such
2 provision, by the organization or any director, offi-
3 cer, or employee of the organization.

4 (2) ENFORCEMENT.—Any employee or former
5 employee who believes that such employee has been
6 discharged or discriminated against in violation of
7 paragraph (1) may file a civil action in the appro-
8 priate United States District Court before the end of
9 the 2-year period beginning on the date of such dis-
10 charge or discrimination.

11 (3) REMEDIES.—If the District Court deter-
12 mines that a violation has occurred, the court may
13 order the organization which committed the
14 violation—

15 (A) to reinstate the employee to the em-
16 ployee's former position;

17 (B) to pay compensatory damages; or

18 (C) to take other appropriate actions to
19 remedy any past discrimination.

20 (4) LIMITATION.—The protections of this sub-
21 section shall not apply to any employee who—

22 (A) deliberately causes or participates in
23 the alleged violation of law or regulation; or

1 (B) knowingly or recklessly provides sub-
2 stantially false information to the Federal or
3 State official involved.

4 (e) PROTECTION OF ADVOCACY FUNCTIONS.—No
5 managed care organization shall terminate, vary the com-
6 pensation or working conditions, or refuse to renew a con-
7 tract for participation with a health care professional be-
8 cause the professional has—

- 9 (1) advocated on behalf of an enrollee,
10 (2) filed a complaint against the organization,
11 (3) appealed a decision of the organization,
12 (4) provided information or filed a report with
13 an appropriate Federal or State official, or
14 (5) requested a hearing or review pursuant to
15 this Act.

16 **SEC. 7. NONDISCRIMINATION AGAINST ENROLLEES AND IN**
17 **THE SELECTION OF PARTICIPATING PRO-**
18 **VIDERS; EQUITABLE ACCESS TO NETWORKS.**

19 (a) NONDISCRIMINATION AGAINST ENROLLEES.—No
20 managed care organization may discriminate (directly or
21 through contractual arrangements) against any enrollee
22 on the basis of age, gender, disability, health status, ge-
23 netic information, or anticipated need for health services.

24 (b) NONDISCRIMINATION IN SELECTION OF PARTICI-
25 PATING HEALTH CARE PROFESSIONALS.—A managed

1 care organization shall not discriminate in selecting par-
2 ticipating health care professionals (or in establishing the
3 terms and conditions for such participation) on the basis
4 of—

5 (1) the race, national origin, gender, age, or
6 disability (other than a disability that impairs the
7 ability of an individual to provide health care serv-
8 ices or that may threaten the health of enrollees) of
9 the professional; or

10 (2) the professional's lack of affiliation with, or
11 admitting privileges at, a hospital (unless such lack
12 of affiliation is a result of infractions of quality
13 standards and is not due to a professional's type of
14 license).

15 (c) NONDISCRIMINATION IN ACCESS TO HEALTH
16 PLANS.—

17 (1) IN GENERAL.—Subject to paragraph (2), a
18 managed care organization shall not discriminate in
19 participation, reimbursement, or indemnification
20 against a health care professional, who is acting
21 within the scope of the professional's license or cer-
22 tification under applicable State law, solely on the
23 basis of such license or certification.

24 (2) CONSTRUCTION.—Nothing in this sub-
25 section shall be construed as a requirement to in-

1 clude for participation every willing health care pro-
2 fessional who meets the terms and conditions of a
3 managed care organization.

4 **SEC. 8. DISCLOSURE OF INFORMATION.**

5 (a) PROVISION OF INFORMATION AND ORIENTA-
6 TION.—

7 (1) GENERAL REQUIREMENT.—A managed care
8 organization offering a managed care plan shall pro-
9 vide enrollees and, upon request, prospective enroll-
10 ees with written information concerning the terms
11 and conditions of the plan, including the information
12 described in subsection (c).

13 (2) INFORMATION UPON REQUEST.—In addition
14 to the information provided under subsection (c), a
15 managed care organization offering a managed care
16 plan shall provide, upon request of an enrollee or
17 prospective enrollee, the information described in
18 subsection (d).

19 (3) REQUIREMENT FOR INITIAL INFORMATION
20 SESSION.—

21 (A) IN GENERAL.—Within 30 days of en-
22 rolling an individual under a managed care
23 plan, the managed care organization shall pro-
24 vide for an in-person information session with

1 the enrollee for the purpose of outlining the in-
2 formation described in this section.

3 (B) PAYMENT.—Such a session shall be
4 held with an enrollee before the enrollee is re-
5 quired to pay for services. This subparagraph
6 shall not affect the coverage of items and serv-
7 ices under the plan immediately upon the effec-
8 tive date of enrollment.

9 (4) COMPARATIVE FORM.—The information
10 provided under this section shall be in a form, speci-
11 fied by the Secretary, so that prospective enrollees
12 may compare the attributes of all such plans offered
13 within a coverage area.

14 (b) UNDERSTANDABILITY.—Information provided
15 under this section, whether written or oral shall be easily
16 understandable, truthful, linguistically appropriate and
17 objective with respect to the terms used.

18 (c) REQUIRED INFORMATION.—Information required
19 under subsection (a)(1) shall include information con-
20 cerning each of the following:

21 (1) COVERAGE AND BENEFITS.—Coverage pro-
22 visions, benefits, and any exclusions by category of
23 service or product, including 24-hour coverage of
24 emergency services without a requirement for prior
25 approval.

1 (2) PRIOR AUTHORIZATION REQUIREMENTS.—
2 Prior authorization requirements for coverage of
3 benefits.

4 (3) UTILIZATION REVIEW POLICIES.—Utiliza-
5 tion review procedures and policies (including
6 preauthorization review, concurrent review, post-
7 service review, post-payment review procedures that
8 may lead an enrollee to be denied coverage for or not
9 be provided a particular service or product), includ-
10 ing time frames for review decisions and enrollee
11 rights relating to notice, reconsideration, and appeal
12 of utilization review decisions, and including infor-
13 mation on the percentage of utilization review deter-
14 minations that disagree with the judgment of the
15 initial treating health care professional and the per-
16 centage of such determinations which are reversed
17 (whether internally or externally) on appeal.

18 (4) PAYMENT METHODS.—Types of methodolo-
19 gies used by the organization to reimburse types of
20 providers or for types of services.

21 (5) ENROLLEE FINANCIAL RESPONSIBIL-
22 ITIES.—Enrollees' financial responsibility for serv-
23 ices, including any variation in the responsibility
24 based on whether the provider is a participating pro-
25 vider.

1 (6) GRIEVANCE PROCEDURES.—Grievance pro-
2 cedures.

3 (7) PROVIDER SELECTION PROCEDURES.—Pro-
4 cedures used by enrollees to select and change pri-
5 mary and specialty providers and to be referred to
6 nonparticipating providers and appropriate special-
7 ists, consistent with the requirements of this Act.

8 (8) ENROLLEE PARTICIPATION IN POLICY DE-
9 VELOPMENT.—Procedures which enrollees may use
10 to participate in development of policy of the organi-
11 zation.

12 (9) PROCEDURES FOR NON-ENGLISH PRO-
13 FICIENT ENROLLEES.—Procedures which the organi-
14 zation has established to meet the needs of enrollees
15 who are not proficient in English.

16 (10) INFORMATION.—An address and phone
17 number at which enrollees and prospective enrollees
18 can obtain information about the organization and
19 managed care plans offered by the organization.

20 (11) LIST OF CONTRACT FACILITIES.—A list,
21 annually updated, of the facilities and providers, by
22 specialty, through which the organization provides
23 its benefits. For each such facility or provider the
24 list shall include the name, address, phone number,
25 and (in the case of a physician) board certification.

1 (12) NON-HEALTH CARE EXPENDITURES.—A
2 statement of the percentage of health-care related
3 revenues of the organization used for administration,
4 the percentage of such revenues used for marketing,
5 and the percentage of such revenues attributable to
6 profit.

7 (13) ENROLLEE SATISFACTION.—Statistics on
8 enrollee satisfaction, stated separately for those who
9 continue enrollment and those who discontinue en-
10 rollment, and on the proportion of enrollees who
11 disenroll.

12 (14) AVAILABILITY OF PROVIDERS; PROVIDER
13 INCENTIVES.—The characteristics and availability of
14 participating health care providers and professionals,
15 including a description of any financial or contrac-
16 tual arrangements with hospitals, utilization review
17 organizations, physicians, or other health care pro-
18 viders or professionals that would affect the services
19 offered, referral or treatment options, or providers'
20 fiduciary responsibility to patients, including any fi-
21 nancial or other incentives regarding the provision,
22 denial, or limitation of needed services.

23 (15) QUALITY INDICATORS.—Indicators that
24 measure the quality of services provided by the orga-
25 nization and by participating health providers with

the organization, including population-based statistics such as immunization rates and performance measures such as survival after surgery, adjusted for case mix.

(16) PHYSICIAN CREDENTIALING STANDARDS.—Standards used by the organization in the credentialing of participating physicians.

(17) FORMULARIES.—Information on prescription drug formularies used by the organization, consistent with section 4(i).

(18) LOSS-RATIO.—Its loss-ratio.

(d) INFORMATION SUPPLIED UPON REQUEST.—For purposes of subsection (a)(2), the information described in this subsection concerning a managed care organization offering a managed care plan is as follows:

(1) ANNUAL FINANCIAL STATEMENT.—The most recent annual financial statement of the organization.

(2) SUBSCRIBER CONTRACT.—A copy of the most recent individual, direct pay subscriber contract, or, in the case of a group health plan, any contract between the plan and a health insurance issuer providing coverage under the plan.

1 (3) CONSUMER COMPLAINTS.—Information re-
2 relating to consumer complaints compiled pursuant to
3 insurance or other law.

4 (4) CHARGES AND BENEFITS FOR SERVICES.—
5 Information on the enrollee charges for all covered
6 items and services, including, for the point of service
7 option described in section 5(e), the amounts that
8 are payable with respect to items and services fur-
9 nished by nonparticipating health care professionals
10 and providers.

11 (5) CONFIDENTIALITY OF MEDICAL
12 RECORDS.—Information on the procedures used by
13 the organization to protect the confidentiality of
14 medical records maintained in relation to enrollees.

15 (6) QUALITY ASSURANCE PROGRAMS.—A de-
16 scription of quality assurance programs maintained
17 by the organization in relation to the plan.

18 (7) COVERAGE OF EXPERIMENTAL OR INVES-
19 TIGATIONAL DRUGS.—A description of procedures
20 used by the organization to determine whether
21 drugs, devices, or treatments in clinical trials are ex-
22 perimental or investigational.

23 (8) PROVIDER AFFILIATIONS.—Information on
24 affiliations of participating health care professionals
25 with participating hospitals.

1 (9) CLINICAL REVIEW CRITERIA.—Upon written
2 request, a description of the specific clinical written
3 review criteria relating to a particular condition or
4 disease and how such criteria are used.

5 (10) PARTICIPATION PROCEDURES AND QUALI-
6 FICATIONS.—A description of the written application
7 procedures and qualification requirements for pro-
8 viders to be considered for participation under the
9 plan.

10 (11) OFFICIALS.—A list of the names, business
11 addresses, and official positions of the membership
12 of the board of directors, officers, or persons with an
13 ownership or control interest in the organization.

14 (e) NOTICE OF TERMINATION OF PROVIDERS.—A
15 managed care organization shall provide written notice to
16 each enrollee within 15 business days of the date that the
17 organization is aware that the participation of a health
18 care provider, that is currently in a course of treating the
19 enrollee, is being withdrawn or terminated. The organiza-
20 tion shall include in such notice the procedures under sec-
21 tion 5(f) for the enrollee to continue to receive care from
22 the provider.

1 **SEC. 9. GRIEVANCE PROCEDURES AND DEADLINE FOR RE-**
2 **SPONDING TO REQUESTS FOR COVERAGE OF**
3 **SERVICES.**

4 (a) GRIEVANCE PROCEDURES.—A managed care or-
5 ganization shall provide meaningful procedures for hear-
6 ing and resolving grievances between the organization (or
7 any entity or individual through which the organization
8 provides health care services) and its enrollees.

9 (b) DETAILS.—The procedures provided under sub-
10 section (a) shall include—

11 (1) recorded (written or otherwise) procedures
12 for registering and responding to complaints and
13 grievances in a timely manner;

14 (2) documentation concerning the substance of
15 complaints, grievances, and actions taken concerning
16 such complaints and grievances, which shall be in
17 writing;

18 (3) procedures to ensure a resolution of a com-
19 plaint or grievance;

20 (4) the compilation and analysis of complaint
21 and grievance data;

22 (5) procedures to expedite the complaint proc-
23 ess if the complaint involves a dispute about the cov-
24 erage of an immediately and urgently needed service;
25 and

1 (6) procedures to ensure that if an enrollee
2 orally notifies the organization about a complaint,
3 the organization (if requested) must send the en-
4 rollee a complaint form that includes the telephone
5 numbers and addresses of member services, and a
6 description of the organization's grievance proce-
7 dure.

8 The Secretary may establish deadlines for the complaint
9 procedures under paragraph (5) in order to ensure timely
10 resolution of disputes involving immediately and urgently
11 needed services.

12 (c) APPEALS PROCESS.—Each managed care organi-
13 zation shall adopt an appeals process to enable enrollees
14 to appeal decisions that are adverse to them. Such a proc-
15 ess shall include—

16 (1) the right to a review by a grievance panel
17 composed of clinical peer professionals who are in
18 the same or similar specialty or field that would pro-
19 vide the item or service involved in the grievance;

20 (2) the right to a second review with a different
21 panel that is independent of the organization and
22 that is composed of clinical peer professionals who
23 are in the same or similar specialty or field that
24 would provide the item or service involved in the
25 grievance, or to a review through an impartial arbi-

1 tration process which shall be described in writing
2 by the organization;

3 (3) a process for completion of review in the
4 case of urgent or emergency care services within 24
5 hours; and

6 (4) covering the costs of all appeals and not im-
7 posing any such costs on an enrollee.

8 The Secretary shall develop guidelines for the structure
9 and requirements applicable to the independent review
10 panel and impartial arbitration process described in para-
11 graph (2).

12 (d) WRITTEN DECISION.—With respect to the com-
13 plaint, grievance, and appeals processes required under
14 this section, the organization shall, upon the request of
15 an enrollee, provide the enrollee a written decision con-
16 cerning a complaint, grievance, or appeal in a timely man-
17 ner consistent with subsections (c)(3) and (f).

18 (e) CONSTRUCTION.—The complaint, grievance, and
19 appeals processes established in accordance with this sec-
20 tion may not be used in any fashion to discourage or pre-
21 vent an enrollee from receiving medically necessary care
22 in a timely manner.

23 (f) PROMPT RESPONSE TO REQUESTS FOR SERV-
24 ICES.—In addition to the procedures available pursuant
25 to the previous provisions of this section, in the case of

1 the request of an enrollee with a managed care
2 organization—

3 (1) the organization shall respond to the re-
4 quest not later than 24 hours after the request is
5 made; and

6 (2) the organization shall hear and resolve the
7 enrollee's appeal of a denial of coverage of such serv-
8 ices in accordance with a process meeting standards
9 established by the Secretary.

10 **SEC. 10. DUE PROCESS FOR HEALTH CARE PROFESSIONALS**
11 **AND PROVIDERS.**

12 (a) IN GENERAL.—A managed care organization
13 shall—

14 (1) allow all health care professionals and pro-
15 viders in its service area to apply to become a par-
16 ticipating health care professional or provider during
17 at least one period in each calendar year;

18 (2) provide reasonable notice to such health
19 care professionals and providers of the opportunity
20 to apply and of the period during which applications
21 are accepted;

22 (3) provide for review of each application by a
23 credentialing committee with appropriate representa-
24 tion of the category or type of health care profes-
25 sional or provider;

1 (4) select participating health care professionals
2 and providers based on objective standards of qual-
3 ity developed with the suggestions and advice of pro-
4 fessional associations, health care professionals, and
5 providers;

6 (5) make such selection standards available
7 to—

8 (A) those applying to become a partici-
9 pating provider or health care professional,

10 (B) health plan purchasers, and

11 (C) enrollees;

12 (6) when economic considerations are taken
13 into account in selecting participating health care
14 professionals and providers, use objective criteria
15 that are available to those applying to become a par-
16 ticipating provider or health care professional and
17 enrollees;

18 (7) adjust any economic profiling to take into
19 account patient characteristics (such as severity of
20 illness) that may result in atypical utilization of
21 services;

22 (8) make the results of such profiling available
23 to insurance purchasers, enrollees, and the health
24 care professional or provider involved;

1 (9) notify any health care professional or pro-
2 vider being reviewed under the process referred to in
3 paragraph (3) of any information indicating that the
4 health care professional or provider fails to meet the
5 standards of the organization;

6 (10) offer a health care professional or provider
7 receiving notice pursuant to the requirement of
8 paragraph (9) with an opportunity to—

9 (A) review the information referred to in
10 such paragraph, and

11 (B) submit supplemental or corrected in-
12 formation;

13 (11) not include in its contracts with partici-
14 pating health care professionals and providers a pro-
15 vision permitting the organization to terminate the
16 contract “without cause”;

17 (12) provide a due process appeal that con-
18 forms to the process specified in section 412 of the
19 Health Care Quality Improvement Act of 1986 (42
20 U.S.C. 11112) for all determinations that are ad-
21 verse to a health care professional or provider; and

22 (13) unless a health care professional or pro-
23 vider poses an imminent harm to enrollees or an ad-
24 verse action by a governmental agency effectively im-

1 pairs the ability to provide health care items and
2 services, provide—

3 (A) reasonable notice of any decision to
4 terminate a health care professional or provider
5 “for cause” (including an explanation of the
6 reasons for the determination),

7 (B) an opportunity to review and discuss
8 all of the information on which the determina-
9 tion is based, and

10 (C) an opportunity to enter into a correc-
11 tive action plan, before the determination be-
12 comes subject to appeal under the process re-
13 ferred to in paragraph (12).

14 (b) LIMITATION ON USE OF NON-COMPETE
15 CLAUSES.—A managed care organization may not (di-
16 rectly or indirectly) seek to enforce any contractual provi-
17 sion which prevents a health care professional or provider
18 whose contractual obligations to the organization for the
19 provision of services through the organization have ended
20 from joining or forming any competing managed care or-
21 ganization, whether or not the organization serves the
22 same geographic area.

23 (c) EQUAL COMPENSATION ARRANGEMENTS.—

24 (1) IN GENERAL.—Subject to paragraph (2), a
25 managed care organization shall provide for com-

1 parable payment for all health care professionals and
2 providers in the same field or specialty located in the
3 same geographic area.

4 (2) ADJUSTMENTS AUTHORIZED.—A managed
5 care organization may adjust the amount of com-
6 pensation among professionals and providers for ex-
7 perience and other relevant factors, including bonus
8 payments that reflect quality factors, such as en-
9 rollee satisfaction and medical chart reviews, unless
10 such payments are based solely on cost-effectiveness
11 of services provided.

12 (d) RULE OF CONSTRUCTION.—The requirements of
13 subsection (a) shall not be construed as preempting or su-
14 perseding any other reviews and appeals a managed care
15 organization is required by law to make available.

16 **SEC. 11. REQUIREMENTS FOR QUALITY IMPROVEMENT**
17 **PROGRAM AND UTILIZATION REVIEW PRO-**
18 **GRAMS.**

19 (a) QUALITY IMPROVEMENT PROGRAM.—

20 (1) IN GENERAL.—A managed care organiza-
21 tion shall establish a quality improvement program
22 (consistent with paragraph (2)) that systematically
23 and continuously assesses and improves—

24 (A) enrollee health status, patient out-
25 comes, processes of care, and enrollee satisfac-

tion associated with health care provided by the organization; and

(B) the administrative and funding capacity of the organization to support and emphasize preventive care, utilization, access and availability, cost effectiveness, acceptable treatment modalities, specialists referrals, the peer review process, and the efficiency of the administrative process.

(2) FUNCTIONS.—A quality improvement program established pursuant to paragraph (1) shall—

(A) assess the performance of the organization and its participating health care professionals and providers and report the results of such assessment to purchasers, participating health care professionals and providers, and administrative personnel;

(B) demonstrate measurable improvements in clinical outcomes and plan performance measured by identified criteria, including those specified in paragraph (1)(A); and

(C) analyze quality assessment data to determine specific interactions in the delivery system (both the design and funding of the health care coverage and the clinical provision of care)

1 that have an adverse impact on the quality of
2 care.

3 (b) UTILIZATION REVIEW.—The utilization review
4 program of a managed care organization shall—

5 (1) be developed (including any screening cri-
6 teria used by such program) with the involvement of
7 participating health professionals and providers;

8 (2) to the extent consistent with the protection
9 of proprietary business information (as defined for
10 purposes of section 552 of title 5, United States
11 Code) release, upon request, to affected health pro-
12 fessionals, providers, and enrollees the screening cri-
13 teria, weighting elements, and computer algorithms
14 used in reviews and a description of the method by
15 which they were developed;

16 (3) uniformly apply review criteria that are
17 based on sound scientific principles and the most re-
18 cent medical evidence;

19 (4) use licensed, accredited, or certified health
20 professionals to make review determinations (and for
21 services requiring specialized training for their deliv-
22 ery, use a health professional who is qualified
23 through equivalent specialized training and experi-
24 ence);

1 (5) subject to reasonable safeguards, disclose to
2 health professionals and providers, upon request, the
3 names and credentials of individuals conducting uti-
4 lization review;

5 (6) not compensate individuals conducting utili-
6 zation review for denials of payment or coverage of
7 benefits;

8 (7) comply with the requirement of section
9 4(d)(1) that prior authorization not be required for
10 emergency and related services furnished in a hos-
11 pital emergency department;

12 (8) make prior authorization determinations—

13 (A) in the case of services that are urgent
14 care services described in section 4(d)(2)(C),
15 within 30 minutes of a request for such deter-
16 mination, and

17 (B) in the case of other services, within 24
18 hours after the time of a request for determina-
19 tion;

20 (9) include in any notice of such determination
21 an explanation of the basis of the determination and
22 the right to an immediate appeal;

23 (10) treat a favorable prior authorization review
24 determination as a final determination for purposes
25 of making payment for a claim submitted for the

1 item or service involved unless such determination
2 was based on false information knowingly supplied
3 by the person requesting the determination;

4 (11) provide timely access, as defined by the
5 applicable State authority, to utilization review per-
6 sonnel and, if such personnel are not available,
7 waives any prior authorization that would otherwise
8 be required; and

9 (12) provide notice of an initial determination
10 on payment of a claim within 30 days after the date
11 the claim is submitted for such item or service, and
12 include in such notice an explanation of the reasons
13 for such determination and of the right to an imme-
14 diate appeal.

15 **SEC. 12. MINIMUM LOSS RATIOS; GENERAL CONSUMER**
16 **PROTECTIONS.**

17 (a) **MINIMUM LOSS RATIO.**—The loss-ratio (as de-
18 fined by the Secretary) for a managed care organization
19 shall not be less than 85 percent with respect to managed
20 care plans it offers.

21 (b) **PARTICIPATION IN POLICY DEVELOPMENT.**—A
22 managed care organization shall have a procedure whereby
23 enrollees may participate in the development of policies of
24 the organization.

1 (c) NEEDS OF NON-ENGLISH PROFICIENT ENROLL-
2 EES.—A managed care organization shall have procedures
3 for addressing the needs of enrollees who are not pro-
4 ficient in English.

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